

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement for dates of service 6-26-01 through 8-10-01.
- b. The request was received on 6-25-02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and Letter Requesting Dispute Resolution
  - b. HCFA(s)
  - c. EOBs/Medical Audit summary
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Letter Responding to Request for Dispute Resolution
  - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 7-24-02. The respondent did not respond to the additional documentation. It's initial response is reflected in Exhibit II.
4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Letter dated 7-5-02:

"...(Provider) billed \$19,762.50, of which \$8,787.00 has been reimbursed by the (Carrier). This leaves a disputed balance of \$10,975.50. The relevant issue involved (Carrier's) contention that the amount they reimbursed (Provider) for the services provided is reasonable. (Provider) billed at a rate of \$150.00 per hour for interdisciplinary, chronic pain management services. (Carrier) reimbursed (Provider) at a rate of \$66.70 per hour. It is (Provider's) assertion that the amount reimbursed is not reasonable, and, in fact, is considerably less than the standard level of reimbursement established in the State of Texas for such services. What follows is evidence that the

average rate of reimbursement is much higher than that provided by (Carrier). (Provider) conducted a study across a large sample of insurance carriers in 45 different chronic pain management programs looking at the reimbursement for 242 chronic pain patients seen by (Provider) from 1998 to the present. This research clearly established that the average rate of reimbursement for chronic pain programs in Texas is \$105.00 per hour...A sample of EOBs also has been included from the major carriers...Our documentation clearly establishes that the (Carrier's) reimbursement rate is almost the very lowest (only one carrier who represented a single patient has a lower rate), and it is substantially lower than the average reimbursement rate and considerably lower than even the reimbursement level of its nearest competitor."

2. Respondent: No position statement noted in dispute packet.

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 6-26-01 through 8-10-01.
2. The carrier denied the billed services as reflected on the EOBs as, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)"; "A TRM1 – THE TREATMENT RENDERED EXCEEDS THE PREAUTHORIZED TREATMENT REQUESTED AND/OR APPROVED."

Reaudit dated 6-12-02; "Per your request, a retrospective review of the original audit for the dates listed above has been completed. Based on this review, it has been determined that no additional reimbursement is recommended. A brief explanation of denial is listed below. "The amount reimbursed is deemed fair and reasonable based on the documentation submitted."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
6-26-01 6-27-01 6-28-01 6-29-01 7-2-01 7-3-01 7-5-01 7-6-01 7-9-01 7-10-01 7-11-01 7-12-01 7-13-01 7-16-01 7-18-01 7-25-01 7-26-01 7-27-01 7-30-01 7-31-01 8-1-01 8-2-01 8-3-01 8-6-01 8-7-01 8-8-01 8-10-01	97799-CP for all dates of service	\$825.00 \$862.50 \$862.50 \$862.50 \$825.00 \$862.50 \$750.00 \$600.00 \$750.00 \$825.00 \$750.00 \$750.00 \$675.00 \$675.00 \$600.00 \$750.00 \$750.00 \$750.00 \$750.00 \$600.00 \$450.00 \$600.00 \$750.00 \$750.00 \$637.50 \$750.00 \$750.00	\$407.00 \$425.50 \$425.50 \$425.00 \$407.00 \$425.50 \$370.00 \$296.00 \$370.00 \$407.00 \$370.00 \$370.00 \$333.00 \$333.00 \$296.00 \$370.00 \$370.00 \$370.00 \$370.00 \$296.00 \$-0- \$296.00 \$370.00 \$370.00 \$314.00 \$-0- \$-0-	M A,M M M M M A,M A,M	DOP No MAR	MFG: Medicine Ground Rules (II) (G); General Instructions (III) (VI); TWCC Rule 133.307 (g) (3) (D); TWCC Rule 133.307 (g) (3) (E); CPT Descriptor	<p>The Carrier has denied the disputed CPT Codes as "M".</p> <p>Documentation supports that the services were rendered as billed. The carrier has reimbursed the provider \$74.00 per hr. The Provider has billed \$150.00 per hr.</p> <p>The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, pursuant to Rule 133.307 (g) (3) (D), the requestor must provide documentation that discusses, demonstrates and justifies the payment request.</p> <p>Originally, the carrier recommended reimbursement in the amount of \$74.00 per hour for all dates of service but three. There are three dates of service where no reimbursement was given (8-1-01) (8-8-01) and (8-10-01). The carrier denied these dates of service originally as "A". However, after reaudit, the denial reflected "M". The documentation for all dates of service in dispute is virtually the same. Therefore, reimbursement is recommended in the amount of \$962.00 for dates of service (8-1-01) (8-8-01) and (8-10-01). (13 hrs of pain management x \$74.00 = <b>\$962.00</b>).</p> <p>For the remaining dates of service, the Provider has submitted non redacted evidence. TWCC Rule 133.307 (g) (3) (E) states, "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party submitting the documentation, to protect the confidential information and the privacy of the individual. Unredacted information or evidence shall not be considered in resolving the medical fee dispute." The Provider has submitted a study of sample insurance carriers regarding what they have reimbursed for Chronic Pain. However, this study in itself is not sufficient to support that the provider's billed amount was fair and reasonable. No additional reimbursement is recommended for the remaining dates of service.</p>
<b>Totals</b>		\$19,762.50	\$8,787.00				The Requestor is entitled to additional reimbursement in the amount of <b>\$962.00</b> .

**V. ORDER**

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **\$962.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 7<sup>th</sup> day of February 2003.

Lesa Lenart  
Medical Dispute Resolution Officer  
Medical Review Division

LL/ll